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Outpatient surgical services performed at Ambulatory Surgical Centers (ASC) must be:

1. provided by a distinct entity that operates exclusively for the purpose of providing surgical services to patients not requiring hospitalization;

2. furnished to outpatients;

3. furnished by a facility that meets the requirements in sections 42 CFR 416.25 - 416.49; and

4. recognized under State law.

Covered surgical procedures may be less than or exceed a total of 90 minutes operating time and a total 4 hours recovery if covered surgical procedures are:

1. commonly performed on an outpatient basis;

2. not of a type that are commonly or safely performed in a physician's office;

3. limited to those requiring a dedicated operating room and generally a post-operative recovery room or short-term (not overnight) convalescent room.

Supplement to
Attachment 3.1A

Service 10
Dental Services

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The following limitations apply to Dental Services:

1. Diagnostic and preventative dental services:
   a. Fluoride treatments are limited to six (6) month intervals.
   b. Full mouth x-rays or panorex x-rays are limited to three (3) year intervals.
   c. Bite-wing x-rays are limited to one (1) year intervals.
   d. Examinations are limited to one (1) year intervals.
   e. Prophylaxis are limited to six (6) month intervals.

2. Restoration:
   a. Gold in-lays are not a benefit

3. Endodontic Services:
   a. Root canal services for third molars are not a benefit.

4. Periodontal Services:
   a. Gingival resections are limited to treatment of gingival hyperplasia due to medication reaction.

5. Crowns and Fixed Bridges:
   a. Crowns are limited to prefabricated stainless steel, or prefabricated resin crowns.
   b. Fixed bridges are limited to anterior teeth.

6. Orthodontic Services are limited to:
   a. Cases that were approved and in active treatment prior to January 1, 2000.
   b. For services provided on or after January 1, 2000, cases involving a possible Cleft/Craniofacial condition syndrome with orthodontic implications or interceptive orthodontia for recipients 12 years of age or younger with either an anterior crossbite or a posterior crossbite with shift.

7. Cosmetic Dental Services:
   Dental services for conditions or ailments considered cosmetic in nature are not a benefit of the Montana Medicaid Program except in such cases where it can be demonstrated the physical well-being and the psycho-social well-being of the recipient are severely affected in a detrimental manner. The Department or its designated review organization will determine whether a service is cosmetic or a recipient's

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physical well-being and psycho-social well-being are severely affected in a detrimental manner.

8. Experimental Services:
Services considered experimental are not a benefit of the Montana Medicaid Program.

Experimental services include:

a. All procedures and items, including prescribed drugs, considered experimental by the U.S. Department of Health and Human Services or any other appropriate federal agency.

b. All procedures and items, including prescribed drugs, provided as part of a control study, approved by the Department of Health and Human Services or any other appropriate federal agency to demonstrate whether the item, prescribed drug or procedure is safe and effective in curing/preventing, correcting or alleviating the effects of certain medical conditions.

c. All procedures and items, including prescribed drugs, which may be subject to question but are not covered in #1 and #2 above, will be evaluated by the Department's designated medical review organization.

9. Prior Authorization:
The following Dental Services require prior authorization by the designated review organization:

1. Extensive oral surgery;

2. Fixed bridges.

3. Orthodontia.

The above limitations apply to diagnostic and preventative dental and orthodontic services provided to individuals under the age of 21 who are eligible for the EPSDT program, based upon medical necessity.

Supplement to
Attachment 3.1A

Service 11a
Physical Therapy

MONTANA

The following Physical Therapy Services require prior authorization by the Department.

1. All services after the first 70 hours per recipient per state fiscal year.

The following limitations apply to Physical Therapy Services:

1. Physical Therapy Services are limited to a maximum of 100 hours per recipient per state fiscal year.

2. Only restorative therapy is a benefit of the Montana Medicaid Program.

3. Limit of 100 hours does not apply to services required as a result of EPSDT screening.

Services considered experimental are not a benefit of the Montana Medicaid Program.

Experimental services include:

1. All procedures and items, including prescribed drugs, considered experimental by the U.S. Department of Health and Human Services or any other appropriate federal agency.

2. All procedures and items, including prescribed drugs, provided as part of a control study, approved by the Department of Health and Human Services or any other appropriate federal agency to demonstrate whether the item, prescribed drug or procedure is safe and effective in curing/preventing, correcting or alleviating the effects of certain medical conditions.

3. All procedures and items, including prescribed drugs, which may be subject to question but are not covered in #1 and #2 above, will be evaluated by the Department's designated medical review organization.

Supplement to
Attachment 3.1A

Service 11b
Occupational Therapy

MONTANA

The following Occupational Therapy Services require prior authorization by the Department.

1. All services after the first 70 hours per recipient per state fiscal year.

The following limitations apply to Occupational Therapy:

1. Occupational Therapy is limited to a maximum of 100 hours per recipient per state fiscal year.

2. Only restorative therapy is a benefit of the Montana Medicaid Program.

3. Limit of 100 hours does not apply to services required as a result of EPSDT screening.

Services considered experimental are not a benefit of the Montana Medicaid Program.

Experimental services include:

1. All procedures and items, including prescribed drugs, considered experimental by the U.S. Department of Health and Human Services or any other appropriate federal agency.

2. All procedures and items, including prescribed drugs, provided as part of a control study, approved by the Department of Health and Human Services or any other appropriate federal agency to demonstrate whether the item, prescribed drug or procedure is safe and effective in curing/preventing, correcting or alleviating the effects of certain medical conditions.

3. All procedures and items, including prescribed drugs, which may be subject to question but are not covered in #1 and #2 above, will be evaluated by the Department's designated medical review organization.

Supplement to
Attachment 3.1A

Service 11c
Speech Therapy Services

MONTANA

The following Speech Therapy Services require prior authorization by the Department.

1. All services after the first 70 visits per recipient per state fiscal year.

The following limitations apply to Speech Therapy Services:

1. Speech Therapy Services are limited to a maximum of 100 visits per recipient per state fiscal year.

2. Only restorative therapy is a benefit of the Montana Medicaid Program.

3. Limit of 100 visits does not apply to services required as a result of EPSDT screening.

Services considered experimental are not a benefit of the Montana Medicaid Program.

Experimental services include:

1. All procedures and items, including prescribed drugs, considered experimental by the U.S. Department of Health and Human Services or any other appropriate federal agency.

2. All procedures and items, including prescribed drugs, provided as part of a control study, approved by the Department of Health and Human Services or any other appropriate federal agency to demonstrate whether the item, prescribed drug or procedure is safe and effective in curing/preventing, correcting or alleviating the effects of certain medical conditions.

3. All procedures and items, including prescribed drugs, which may be subject to question but are not covered in #1 and #2 above, will be evaluated by the Department's designated medical review organization.

Supplement to
Attachment 3.1A

Service 11c
Audiology Therapy Services

MONTANA

The following limitations apply to Audiology Services:

1. Audiology Services are limited to services provided by a licensed audiologist to individuals with hearing disorders.

2. This limitation does not apply to services required as a result of an EPSDT Screening.

Services considered experimental are not a benefit of the Montana Medicaid Program.

Experimental services include:

1. All procedures and items, including prescribed drugs, considered experimental by the U.S. Department of Health and Human Services or any other appropriate federal agency.

2. All procedures and items, including prescribed drugs, provided as part of a control study, approved by the Department of Health and Human Services or any other appropriate federal agency to demonstrate whether the item, prescribed drug or procedure is safe and effective in curing/preventing, correcting or alleviating the effects of certain medical conditions.

3. All procedures and items, including prescribed drugs, which may be subject to question but are not covered in #1 and #2 above, will be evaluated by the Department's designated medical review organization.

Service 12a
Prescribed Drugs

MONTANA

Drugs covered by the Medicaid Program are subject to the following limitations:

1. Drugs must be prescribed by a physician or other licensed practitioner who is authorized by law to prescribe drugs and is recognized by the medicaid program;

2. Coverage is limited to legend drugs and those over-the-counter drugs which are included in the department drug formulary;

3. Prescriptions may not be dispensed in quantities greater than 100 dosages or a 34-day supply, whichever is greater;

4. Drugs are not covered if they:
   a. Have been classified as "less than effective" by the FDA (DESI drugs);
   b. Are used for hair growth;
   c. Are used as fertility agents;
   d. Are produced by manufacturers who have not signed a rebate agreement with HCFA.

Services considered experimental are not a benefit of the Montana Medicaid Program.

Experimental services include:

1. All procedures and items, including prescribed drugs, considered experimental by the U.S. Department of Health and Human Services or any other appropriate federal agency.

2. All procedures and items, including prescribed drugs, provided as part of a control study, approved by the Department of Health and Human Services or any other appropriate federal agency to demonstrate whether the item, prescribed drug or procedure is safe and effective in curing/preventing, correcting or alleviating the effects of certain medical conditions.

3. All procedures and items, including prescribed drugs, which may be subject to question but are not covered in #1 and #2 above, will be evaluated by the Department's designated medical review organization.

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Product Restrictions:

The Medicaid program restricts coverage of certain drug products through the operation of an outpatient drug formulary. The state utilizes the University of Montana, School of Pharmacy and Allied Health Sciences for literature research and the state DUE CARE (Drug Utilization Review, Concurrent and Retrospective Evaluation) Board as the formulary committee. Criteria used to include/exclude drugs from the formulary is based upon safety, efficacy and clinical outcomes as provided by the product labeling of the drug.

Prior Authorization:

Drugs not included in the formulary are considered for coverage through a prior authorization program. Prescribing physicians, pharmacists and/or designated representatives may contact the Medicaid PA unit via 1-800 phone and fax lines or by mail. Responses are issued within 24 hours of the request. Pharmacies are authorized to dispense a 72 hour supply of a prior authorized product in the event of an emergency. The program complies with requirements set forth in OBRA 1990 and 1993 pertaining to prior authorization programs.

Supplement to
Attachment 3.1A
Service 12b
Dentures

MONTANA

The following prior authorizations are required for Dentures:

1. All full dentures must be prior authorized.

2. All partial dentures must be prior authorized.

3. All relines must be prior authorized.

4. All jumps must be prior authorized.

5. All replacement dentures must be prior authorized.

1. Replacement of dentures is allowed when one of the following circumstances occurs:

   a. Partial dentures that are at least five years old may be replaced by full dentures.
   b. It is determined that the existing dentures are causing the patient serious physical medical problems.

2. Jumping is allowed for dentures between five (5) and ten (10) years old.

3. Relines are allowed at three (3) year intervals, except that the first relines of immediate dentures are allowed three months after placement of the dentures.

The following limitations apply to Dentures:

Services considered experimental are not a benefit of the Montana Medicaid Program.

Experimental services include:

1. All procedures and items, including prescribed drugs, considered experimental by the U.S. Department of Health and Human Services or any other appropriate federal agency.

2. All procedures and items, including prescribed drugs, provided as part of a control study, approved by the Department of Health and Human Services or any other appropriate federal agency to demonstrate whether the item, prescribed drug or procedure is safe and effective in curing/preventing, correcting or alleviating the effects of certain medical conditions.

3. All procedures and items, including prescribed drugs, which may be subject to question but are not covered in #1 and #2 above, will be evaluated by the Department's designated medical review organization.